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No. 96-1476

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

ALLSTATE LIFE INSURANCE COMPANY
Petitioners,

v.

MICHAEL HIBMA, *et al.*,
Respondent.

On Petition for a Writ of Certiorari to the Court of Appeals of the State of Arizona

MOTION TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* FOR THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") hereby move, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as *amici curiae*. Counsel for the petitioner has consented to the filing of this brief; counsel for the respondent has refused consent.

ACLI represents 557 member companies that underwrite most of the nation's life insurance. HIAA represents more than 250 health insurance companies that cover more than 60 million Americans. These companies frequently serve as administrators or claims fiduciaries of employee benefit plans.

Defining which rules of law govern employee benefit plans and plan administrators is of vital importance to ACLI and HIAA. The state court decision below and others like it—which hold that ERISA does not apply to plans that are arranged and paid for by the employer--through an independent insurance company, but that are not administered by the employer conflict with Congress's intent in ERISA, with the decisions of many federal courts of appeals, and with the Department of Labor's regulations construing ERISA. These state court decisions threaten to eliminate ERISA coverage for the most common variety of employee benefit plan.

As a result of their significant experience in administering such plans, *amici* bring a unique perspective to this case. As the attached brief seeks to demonstrate, decisions like the one below have created considerable confusion for plan administrators, including ACLI's and HIAA's member companies, as to whether their rights and obligations are to be governed by federal or state law.

For these reasons, the Court should grant this motion for leave to file the attached brief *amici curiae* in support of the petition for certiorari.

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF THE AMICI CURIAE 1

INTRODUCTION AND SUMMARY 2

REASONS FOR GRANTING THE PETITION 4

I. THE CURRENT CONFUSION IN THE LAW DEFINING ERISA-COVERED PLANS UNDERMINES THE PURPOSES OF ERISA 4

II. THE DECISION BELOW SHARPLY CONFLICTS WITH ESTABLISHED FEDERAL PRECEDENT REGARDING THE DEFINITION OF A PLAN UNDER ERISA 6

III. THIS ISSUE IS RECURRING AND IMPORTANT 9

CONCLUSION 11

TABLE OF AUTHORITIES

Page

Cases

Belasco v. W.K.P. Wilson & Sons, 833 F.2d 277 (11th Cir. 1987) 8
Blue Cross/Blue Shield of Florida, Inc. v. Weiner, 543 So. 2d 794 (Fla. Ct. App. 1989), *cert. denied*, 494 U.S. 1028 (1990) 7
Brundage-Peterson v. Compcare Health Services Insurance Corp., 877 F.2d 509 (7th Cir. 1989) 7, 9
Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) . . 8
Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 5, 9, 10
Fugarino v. Hartford Life and Accident Insurance Co., 969 F.2d 178 (6th Cir. 1992), *cert denied*, 507 U.S. 966 (1993) 8, 9
Grimo v. Blue Cross/Blue Shield of Vermont, 34 F.3d 148 (2d Cir. 1994) 8
Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) 4, 5, 10
Kanne v. Connecticut General Life Insurance Co., 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989) 8, 9
Kornman v. Blue Cross/Blue Shield of Louisiana, 662 So. 2d 498 (La. Ct. App. 1995), *cert. denied*, 116 S. Ct. 2527 (1996) 7
Madonia v. Blue Cross & Blue Shield of Virginia, 11 F.3d 444 (4th Cir. 1993), *cert. denied*, 511 U.S. 1019 (1994) 8
Massachusetts v. Morash, 490 U.S. 107 (1989) 8
Memorial Hospital System v. Northbrook Life Insurance Co., 904 F.2d 236 (5th Cir. 1990) 8
Nachman Corp. v. Pension Benefit Guaranty Corp., 446 U.S. 359 (1980) 4

TABLE OF AUTHORITIES
(Continued)

Page

New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 115 S. Ct. 1671 (1995) 5
Peters v. Boulder Insurance Agency, Inc., 829 P.2d 429 (Colo. Ct. App. 1991) 7
Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 10
Qualls v. Blue Cross of Calif., 22 F.3d 839 (9th Cir. 1994) 8
Robertson v. Gem Insurance Co., 828 P.2d 496 (Utah Ct. App. 1992) 6, 9
Roe v. General America Life Insurance Co., 712 F.2d 450 (10th Cir. 1983) 8
Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) 4, 5
Williams v. Wright, 927 F.2d 1540 (11th Cir. 1991) 8

Statutes and Regulations

The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 . . . . . 1, 4
29 U.S.C. § 1144(a)(1994) 4
29 U.S.C. § 1161(a) (1994) 10
29 C.F.R. 2510.3-1 (1996) 8

Legislative History

H.R. Rep. No. 94-1785, 94 Cong., 2d Sess. (1977) 4
120 Cong. Rec. 29197 (1974) 5
120 Cong. Rec. 29933 (1974) 5

Miscellaneous Authority

Reorg. Plan No. 4 of 1978, 43 Fed. Reg. 47,713 (1978) . . 8

INTEREST OF THE AMICI CURIAE[1]

The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") represent the nation's providers of life, disability, health, and other insurance. ACLI represents 557 member companies that underwrite most of the nation's life and disability insurance. HIAA represents more than 250 health insurance companies that cover more than 60 million Americans.

As insurers, ACLI's and HIAA's member companies are integrally involved in the provision of insurance benefits through employee benefit plans that are covered by ERISA. These companies frequently serve as ERISA plan administrators or claims fiduciaries. They consequently have a vital interest in legal questions affecting the interpretation of ERISA, in promoting uniform and consistent rules of ERISA plan administration and ERISA coverage, and in preserving uniformity in the interpretation of the definition of a plan under ERISA.

The legal and practical consequences of the Arizona Court of Appeals' decision, and others like it, are of grave concern to ACLI, HIAA, and their member companies. In holding that ERISA does not apply to employee medical insurance that an employer obtains and pays for through an insurance company, if the employer delegates to the insurance company the administration of the insurance benefits, these decisions would eliminate ERISA coverage of the most common variety of employee benefit plan. *See* Pet. 2 (noting that more than 148 million Americans are covered by private-sector employer-sponsored group health insurance similar to the coverage in this case). ACLI and HIAA seek to provide this Court with the unique perspective of their broad-based constituencies on this important federal question.

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[1] No counsel for any party had any role in authoring this brief, and no person other than the named *amici* and their counsel made any monetary contribution to its preparation and submission.

INTRODUCTION AND SUMMARY

This case implicates an important and recurring issue under the Employee Retirement Security Act of 1974: whether an employer establishes an "employee benefit plan" within the scope of ERISA by selecting, applying for, and buying a health insurance policy for its employees—even if the employer does not administer the insurance policy itself, but instead delegates that task to the insurance company. The Arizona Court of Appeals held that an ERISA-covered plan was not established in these circumstances, and thus that an insured's state-law claims with respect to the insurance policy were not preempted by ERISA.

In 1987, the employer in this case, Prescott Glass, applied to Allstate Life Insurance Company for major medical group insurance to cover its two employees. Prescott paid the initial application fees and at least some of the monthly premiums as a benefit to the employees. Allstate administered Prescott's insurance program. As required by ERISA, Allstate provided Prescott and the employees with plan documents describing the medical insurance policy and the procedures for filing claims for benefits. Under the policy, Allstate had the right to terminate with 60 days' written notice. In 1989, Allstate exercised its rights under the policy and notified Prescott that it was terminating the policy, as it was withdrawing from the group health insurance market.

An individual who was covered under the insurance policy then filed this suit against Allstate in Arizona state court, asserting state-law causes of action for, *inter alia*, breach of contract, breach of fiduciary duty, bad faith, fraud, and negligence. Allstate moved for summary judgment on the ground that Prescott's insurance policy constituted an "employee welfare benefit plan" within the meaning of ERISA and, therefore, that ERISA preempted all of the plaintiff's state-law claims.

The trial court denied Allstate's motion, and the Arizona Court of Appeals affirmed, holding that Prescott did not establish an ERISA-covered plan by obtaining and paying for the Allstate insurance policy. The court reasoned that "garden variety

employee health insurance benefits" are not covered by ERISA, unless the employer, as opposed to the insurance company, engages in "administrative activity" with respect to those benefits. Pet. App. 3a-4a. Accordingly, because Prescott did not administer the insurance program at issue here, the court held that the plaintiff's state-law claims were not preempted. The Arizona Supreme Court denied review.

The questions presented by Allstate's Petition require the Court's attention for two reasons. First, the decision below undermines the congressional intent for ERISA of ensuring uniformity in the operation and regulation of employee benefit plans. This uniformity is, as Congress recognized, advantageous for all those who sponsor, administer, or participate in employee benefit plans. Under the approach taken by the Arizona courts in this case, state courts are given free rein to apply their own standards to determine whether an employee benefit plan is covered by ERISA, thereby opening the door to conflicting rules of law in the federal and state systems regarding the duties and liabilities of plans and plan administrators.

Second, the decision below, together with the similar decisions of other state appellate courts, squarely conflicts with the decisions of federal courts of appeals as to what constitutes an employee benefit plan covered by ERISA. It also conflicts with the Department of Labor's "safe harbor" regulations, which define when an employer's activity is too minimal to create an ERISA-covered plan. Without clarification by this Court of the proper standard to apply, neither plan administrators, nor plan sponsors, nor plan participants can have any certainty about their rights and obligations, thus undermining the purposes of an important federal statute.

REASONS FOR GRANTING THE PETITION

I. THE CURRENT CONFUSION IN THE LAW DEFINING ERISA-COVERED PLANS UNDERMINES THE PURPOSES OF ERISA

The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 ("ERISA"), imposed a comprehensive scheme of federal regulation on plans established by employers to provide employees with fringe benefits. ERISA was designed to balance the interests of employees and their families in obtaining secure and well-administered benefits, with the interests of employers and plan administrators in having their duties with respect to such benefits clearly defined. To that end, Congress provided that the rights and obligations of all parties to ERISA-covered employee benefit plans were to be controlled by a single body of law—federal law. *See Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361-362 (1980).

Section 514(a) of ERISA, 29 U.S.C. § 1144(a) (1994), contains a broad preemption provision. It exempts ERISA plans from "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," with a few exceptions not at issue in this case. The sweep of this provision is expansive because Congress's purpose was to eradicate *any* potentially inconsistent state or local regulation of employee benefit plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 141 (1990).

The need for uniformity in the law governing employee benefit plans was a recurring theme in the congressional discussions following the enactment of ERISA. The House Report, for example, emphasized that "'the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.'" *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983) (quoting H.R. Rep. No. 94-1785 at 47, 94th Cong., 2d Sess. (1977)).

Indeed, this Court has recognized that Congress's "crowning achievement" in ERISA was its "reservation to Federal authority the sole power to regulate the field of employee benefit plans,"

thereby "round[ing] out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." *Shaw*, 463 U.S. at 99 (quoting Representative Dent, one of ERISA's sponsors, *see* 120 Cong. Rec. 29197 (1974)). The elimination of inconsistency was "intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law." 463 U.S. at 99 (quoting Senator Williams, another ERISA sponsor, *see* 120 Cong. Rec. 29933 (1974)).

As the Court has observed, in preempting the field of employee benefit law for federal regulation, Congress accomplished several salutary purposes. These include "minimiz[ing] the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government" and preventing "the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. For example, in the absence of ERISA's preemption provision,

> [a] plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987); *see also New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1677-78 (1995) ("The basic thrust of the [ERISA] pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.").

The decision below, together with others like it, gives rise to precisely what Congress sought to avoid in ERISA: "conflicting and inconsistent State and local regulation" that, if allowed to stand, will necessitate "the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." Such

a result cannot be reconciled with the plain language and legislative history of ERISA.

II. THE DECISION BELOW SHARPLY CONFLICTS WITH ESTABLISHED FEDERAL PRECEDENT REGARDING THE DEFINITION OF A PLAN UNDER ERISA

Federal courts have, consistent with Congress's intent in ERISA, applied a broad construction of when an employer has "established or maintained" an employee benefit plan within the meaning of ERISA. But some state appellate courts have taken a much narrower approach, thereby exempting a large number of employee benefit programs from ERISA. These courts have, like the court below, construed ERISA to apply only to plans administered by the employer itself, as opposed to the vast majority of plans administered by insurance companies or other third parties. This construction of ERISA conflicts with the decisions of several federal courts of appeals, as well as with the regulations issued by the Department of Labor.

In this case, although the employer had obtained the group medical insurance policy for its employee and paid some or all of the premiums for their coverage, the Arizona Court of Appeals refused to find that an ERISA-covered plan had thereby been created. In so holding, the court accorded "critical importance" to the fact that the employer's own involvement in the administration of the plan was only "negligible." Pet. App. 3a, 4a, 12a. The Arizona court adopted this analysis from *Robertson v. Gem Insurance Co.*, 828 P.2d 496 (Utah Ct. App. 1992), which had likewise placed decisive weight on whether the employer itself was the administrator of the employee benefits. The Utah court had reasoned that "the regulatory concerns of ERISA are not implicated" where an employer, after setting up an employee benefit plan, does not engage in "administrative activity" with respect to the plan, but instead delegates administration to a third party. *Id.* at 502-03 (quotation omitted). Consistent with this case and *Robertson*, other state appellate courts, in assessing whether an employee benefit plan is covered

by ERISA, have focused on the extent of the employer's role in plan administration.[2]

A number of federal appellate decisions, in contrast, have recognized that an employee benefit plan is covered by ERISA, whether or not the employer administers the plan itself or delegates that task to an insurance company or other third party. A leading decision in this regard is *Brundage-Peterson v. Compcare Health Services Insurance Corp.*, 877 F.2d 509 (7th Cir. 1989), which held that an ERISA-covered plan existed on facts strikingly similar to those in this case.

In *Brundage-Peterson*, as here, the employer had arranged for medical insurance for its employees, paid the premiums for the employees' coverage, and delegated administration of the benefits to the insurers. Also as here, the plaintiff argued that these insurance benefits were not a "plan" under ERISA, and thus that state-law claims concerning those benefits were not preempted by ERISA. The Seventh Circuit, in an opinion by Judge Posner, recognized that even such a concededly "barebones" benefit plan came within the coverage of ERISA. *Id.* at 511. The court observed that ERISA "by its express terms encompasses the provision of [employee health and welfare] benefits by means of insurance"—a mechanism that necessarily entails little, if any, employer "participation in the actual provision of the benefits." *Id.* The court went on to observe that "delegation of administration of the plan to an insurance company" is "in fact contemplated by the statute." *Id.*

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[2] *See, e.g., Peters v. Boulder Ins. Agency, Inc.*, 829 P.2d 429 (Colo. Ct. App. 1991) (no ERISA coverage where employer did not maintain any significant administrative role in operation of group insurance plan); *Blue Cross/Blue Shield of Florida, Inc. v. Weiner*, 543 So. 2d 794 (Fla. Ct. App. 1989) (no ERISA coverage although employer obtained medical insurance policy for employees and paid premiums), *cert. denied*, 494 U.S. 1028 (1990); *Kornman v. Blue Cross/Blue Shield of Louisiana*, 662 So. 2d 498 (La. Ct. App. 1995) (no ERISA coverage where employer, after obtaining and paying for insurance, delegated administration to Blue Cross), *cert. denied*, 116 S.Ct. 2527 (1996).

Other federal courts of appeals have found ERISA-covered plans to exist in similar circumstances. For example, the Sixth Circuit has held that an employer establishes an ERISA-covered employee benefit plan simply by obtaining a medical insurance policy for its employees and paying the premiums on the policy. *Fugarino v. Hartford Life and Accident Ins. Co.*, 969 F.2d 178, 184 (6th Cir. 1992), *cert denied*, 507 U.S. 966 (1993). It was not necessary that the employer participate in the administration of the benefits. *Id.* The same approach to determining whether an employer has, in fact, established an ERISA-covered plan has been employed by the Second, Fourth, Fifth, Ninth, Tenth, and Eleventh Circuits.[3]

Not only does the decision below, together with *Robertson* and similar state appellate decisions, conflict with the decisions of eight federal circuits, but it also is inconsistent with the federal Department of Labor's "safe-harbor" regulation, 29 C.F.R. 2510.3-1(j) (1996), which provides guidance as to when an employer may assist its employees in obtaining their own insurance without being deemed to have created an ERISA-covered plan.[4] Under this regulation, an employer who obtains insurance for its employees will be deemed to have

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[3] *See, e.g., Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148 (2d Cir. 1994); *Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444 (4th Cir. 1993), *cert. denied*, 511 U.S. 1019 (1994); *Memorial Hospital Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Qualls v. Blue Cross of Calif.*, 22 F.3d 839 (9th Cir. 1994); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989); *Roe v. General Am. Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983); *Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991); *Belasco v. W.K.P. Wilson & Sons*, 833 F.2d 277 (11th Cir. 1987); *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982).

[4] The Department of Labor has the authority to interpret the provisions of Title I of ERISA. *See* Reorg. Plan No. 4 of 1978, 43 Fed. Reg. 47,713 (1978). *See also Massachusetts v. Morash*, 490 U.S. 107, 116-19 (1989) (giving deference to Labor Department's regulations in 29 C.F.R. § 2510.3-1 and its interpretations thereunder).

created an ERISA-covered plan *unless* the employer can satisfy each of four requirements. Among these requirements are that the employer pay no portion of the employees' insurance and that the employer's "sole function" be "to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs, and to remit them to the insurer." *Id.* While the federal courts of appeals have sought to define ERISA-covered plans consistently with this regulation—*see, e.g.*, *Fugarino*, 969 F.2d at 184; *Brundage-Peterson*, 877 F.2d at 511; *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492-93 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989)—the court below and other state courts have disregarded the regulation, *see* Pet. App. 3 (quoting *Robertson*, 828 P.2d at 503).

In sum, the Seventh Circuit observed in *Brundage-Peterson* that, if the question whether a given employee benefit plan is covered by ERISA were left to the sort of "complicated, variable, case-by-case standard" applied below, the result would be unwarranted "uncertainty and litigation." 877 F.2d at 511. "Employers, employees, and insurance companies would have no clear idea whether their rights and obligations were defined by federal law or by state law." *Id.* Yet, the state appellate courts are creating that very "uncertainty" through decisions like the one in this case—decisions that cannot be reconciled with *Brundage-Peterson*, with the decisions of seven other federal courts of appeals, and with the "safe-harbor" regulation issued by the Department of Labor. This Court's intervention is necessary in order to resolve these two conflicting lines of authority.

III. THIS ISSUE IS RECURRING AND IMPORTANT

The decision below, and the growing number of others like it, create the sort of "patchwork scheme of regulation" of employee benefit plans that, as this Court has recognized, gives rise to "considerable inefficiencies in [plan] operation." *Fort Halifax*, 482 U.S. at 11. These inefficiencies have severe consequences not only for insurance companies that administer employee benefit plans, but also for employers who have chosen to provide

employee benefits through insurance companies, and for employees and their families.

The members of ACLI and HIAA, who administer insured employee benefit plans, are most immediately affected by these decisions. They will be required to ascertain and comply not only with ERISA's extensive requirements, but also with potentially inconsistent state-law requirements in every jurisdiction where their plans operate. A single plan administered by one of these companies may, of course, operate in a number of states at the same time. Accordingly, these companies will be required, contrary to Congress's intent in ERISA, to "tailor[ ]" their plans, and their conduct in administering those plans, "to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. And, if they fail to do so to the satisfaction of the state courts, they may be subject to penalties, such as punitive damages, that are foreclosed under ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987).

It is not only insurance companies and other plan administrators, however, that will bear the burdens of this confusion. In order to offset their costs of conforming to conflicting legal standards and their increased litigation exposure, insurers may have to raise premiums, curtail benefits, or even cease to do business in particular states. In turn, "those employers with existing plans [may] reduce benefits, and those without such plans [may] refrain from adopting them." *Fort Halifax*, 482 U.S. at 11.

Employees and other plan beneficiaries not only may suffer a reduction in their current insurance benefits as a result of decisions such as the one below, but also may lose the considerable protections afforded them by ERISA. For example, they would be deprived of their COBRA right to continued insurance coverage for a period after leaving employment. *See* 29 U.S.C. § 1161(a) (1994). The Arizona Court of Appeals' decision provides a road map for benefits providers to escape ERISA applicability for their plans. Employers need only delegate administrative authority to a third party in order to opt out of the

statute, effectively denying employees the very protections envisioned by ERISA.

Only this Court can finally resolve the confusion among the federal and state courts over what constitutes an ERISA-covered employee benefit plan. This important issue of plan definition should be decided now. It will only increase the costs and reduce the availability of employee benefits—to the detriment of employers, employees, and their families—to allow this issue to percolate any further in the lower courts.

CONCLUSION

For the foregoing reasons, *amici* urge the Court to grant certiorari in this case.

Respectfully submitted,

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